



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SOUTH TEXAS HEALTH SYSTEM  
3255 W PIONEER PKWY  
ARLINGTON TX 76013-4620

#### **Respondent Name**

City of McAllen

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-10-1794-01

#### **MFDR Date Received**

November 17, 2009

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Please submit this claim for the correct allowable per ASC RULE 134.402:Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

**Amount in Dispute:** \$449.30

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Carrier contends that reimbursement in the above case has been calculated correctly per the out-patient hospital fee guidelines, and no further reimbursement is owed."

**Response Submitted by:** Parker & Associates, L.L.C. 7600 Chevy Chase Dr., Suite 350, Austin, TX 78752

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2009	Outpatient Hospital Services	\$449.30	\$236.38

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 30, 2009

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.

Explanation of benefits dated August 26, 2009

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Per Medicare policy, procedure code 96374, date of service May 21, 2009, may not be reported with the procedure code for another service billed on this same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 96374, date of service May 21, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$21.68. This amount

multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$19.63. The non-labor related portion is 40% of the APC rate or \$14.45. The sum of the labor and non-labor related amounts is \$34.08. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this line is \$34.08. This amount multiplied by 200% yields a MAR of \$68.16.

- Procedure code 99284, date of service May 21, 2009, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC 8003. Review of the submitted information finds that the criteria for composite payment have not been met. Separate payment is allowed. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$217.91. This amount multiplied by 60% yields an unadjusted labor-related amount of \$130.75. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$118.37. The non-labor related portion is 40% of the APC rate or \$87.16. The sum of the labor and non-labor related amounts is \$205.53. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this line is \$205.53. This amount multiplied by 200% yields a MAR of \$411.06.
  - Procedure code J1885, date of service May 21, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code Q9967, date of service May 21, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure codes 71260, 72125, 72193, and 74160, date of service May 21, 2009, have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT procedure is performed on the same date of service as a "with contrast" CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which, per OPPS Addendum A, has a payment rate of \$635.10. This amount multiplied by 60% yields an unadjusted labor-related amount of \$381.06. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of \$344.97. The non-labor related portion is 40% of the APC rate or \$254.04. The sum of the labor and non-labor related amounts is \$599.01. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.1467. This ratio multiplied by the billed charge of \$13,111.00 yields a cost of \$1,923.38. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$599.01 divided by the sum of all APC payments is 71.43%. The sum of all packaged costs is \$82.56. The allocated portion of packaged costs is \$58.97. This amount added to the service cost yields a total cost of \$1,982.35. The cost of these services exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$934.08. 50% of this amount is \$467.04. The total APC payment for this line, including outlier payment, is \$1,066.05. This amount multiplied by 200% yields a MAR of \$2,132.10.
4. The total allowable reimbursement for the services in dispute is \$2,611.32. This amount less the amount previously paid by the insurance carrier of \$2,374.94 leaves an amount due to the requestor of \$236.38. This amount is recommended

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$236.38.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$236.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

_____	_____	April 3, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**